D H E C
PROMOTE PROTECT PROSPER
South Carolina Department of Health and Environmental Control

Application For License to Operate an Inpatient Care Facility Division of Health Licensing

In accordance with §44-7-260 and §44-71-10, of the South Carolina Code Ann. (Suppl. 2001) and Regulations 61-13, 61-16, 61-17, 61-78, 61-90, 61-93 and 61-103, licensees and prospective licensees must file an application under oath prior to operating a health care facility, and annually thereafter. Licenses are effective for a 12-month period following the date of issue.

1. A. _____
(Name of facility to be licensed)

B. _____
(Street address or location)

_____
(City) (County) (Zip code) (Telephone #)

C. _____
(Mailing address if different) City State Zip

D. _____
(E-mail Address)

2. Reason for application (check one or more):

A. ☐ New activity or service (Initial License)

B. ☐ Renewal of license #_____ which expires _____.

C. ☐ Change of: (Attach copy of Certificate of Need (CON) letter of approval/exemption, if applicable.)

☐ (1) licensee from _____

to_____

☐ (2) name of activity from_____

to_____

☐ (3) address of activity from_____

to_____

☐ (4) number of licensed units from_____ to _____.

NOTICE: *Your license must be renewed prior to the expiration date. The current licensee is responsible for renewal of the license prior to the expiration date regardless of any changes or pending approvals (i.e., ownership changes or bed increases/decreases) from the Department that are in progress at the time the license is due for renewal. To avoid a lapse in your license, please submit an application to renew the current license and a second application to effect the changes.*

3. **Administrative Officer** (Facility Contact): **Prefix:** Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other: ____
First Name: _____ **MI:** ____ **Last Name:** _____
Generation: Sr. ☐ Jr. ☐ III ☐ Other: _____ **Suffix:** MD ☐ Ph.D. ☐ RN ☐ Other: _____
Title: _____

(**Nursing Homes Only**) Administrator's License Number: _____ Expires: _____ (As issued by the SC Board of Long Term Care Administrators, Department of Labor Licensing and Regulation)

4. Type of facility for which application is made: (**Check only one category per application**)

A. ☐ **Intermediate Care Facility for the Mentally Retarded (Regulation 61-13)**
Number of Beds: _____

B. ☐ **Hospital or Institutional General Infirmary (Regulation 61-16)**

☐ General Hospital ☐ Institutional General Hospital ☐ Institutional General Infirmary
☐ Specialized Hospital (Specialty):_____

Certified to perform abortions? ☐ Yes; ☐ No (Request to Health Licensing must be on file.)

Number of beds to be licensed: General _____; Psychiatric _____; Rehabilitation _____; Substance abuse _____; **Total Number of Beds: _____**

Do you operate a swing bed unit? ☐ Yes; ☐ No. Number of Beds: _____

Does your hospital provide perinatal (obstetrics and newborn) services? ☐ Yes; ☐ No.

If yes, indicate the appropriate level: ☐ I; ☐ II; ☐ III; ☐ III Regional Center.

If licensed at Level II or III, how many NICU and Neonatal Special Care (Intermediate and Continuing Care) neonates are you capable of caring for? NICU____ Neonatal Special Care ____

Are you JCAHO accredited? ☐ Yes; ☐ No. Date of Last JCAHO Inspection: _____

C. ☐ **Nursing Home (Regulation 61-17)**
(1) ☐ Nursing Home Number of Beds: _____
(2) ☐ Institutional Nursing Home Number of Beds: _____
Total Number of Beds: _____

D. ☐ **Residential Treatment Facility for Children & Adolescents (Regulation 61-103)**
Number of Beds: _____

E. ☐ **Chiropractic Facility (Regulation 61-90)** Number of Beds: _____

F. ☐ **Treatment Facility for Psychoactive Substance Abuse or Dependence (Regulation 61-93)**

____ Number of Medical Detoxification Beds (Requires CON Approval)
____ Number of Social Detoxification Beds
____ Number of Residential Treatment Program Beds
____ Total Number of Beds to be Licensed

G. ☐ **Hospice Facility (Regulation 61-78)** Number of Beds: _____

5. If you checked 4.C:

A. Does your facility provide or offer to provide Alzheimer's special care services? ☐ Yes ☐ No

B. If yes, does your facility have a designated area specifically designed to care for Alzheimer patients? ☐ Yes ☐ No Name of Designated Area: _____

C. If you answered yes to 5.A or 5.B, how many Alzheimer patients are you able to accommodate?_____

6. In how many buildings are patient/resident rooms located? _____

A. Name of building — No. of beds

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

B. If any facility services or functions are located in buildings other than those named above, attach a description of the functions and name of building(s) (and location if at an address other than that of the hospital).

7. Attach a brief description of any construction or renovations in progress; identify location, percent of completion, expected completion date, and if applicable Certificate of Need.

8. A. Chief of Medical Staff/Medical Director/Physician on Call **(Applicable only to Line 4.A.)**:

_____
(Name and License Number)

B. Director of Nursing: _____

_____ _____
(Certificate Number) (Renewal Number)

9. Licensee (The legal entityor its governing body that has the ultimate responsibility and authority for the conduct of the facility or service; the owner of the business with which rests the ultimate responsibility for maintaining approved applicable licensing standards for the facility. If applicable, the licensee must be the entity to which the Certificate of Need has been issued or that has been exempted from Certificate of Need review.)

A. _____
(Name)

B. _____
(Mailing address) (City) (State) (Zip Code)

C. Check one of following characteristics in each of the three categories that applies to the licensee:

(1) ☐ Profit ☐ Not for Profit (Non Profit)

(2) ☐ State Government ☐ County Government ☐ District Government
☐ Religious ☐ Commercial ☐ None in these categories apply

(3) ☐ Sole proprietorship ☐ Partnership ☐ Limited Partnership ☐ Corporation
☐ Limited Liability Company ☐ None in these categories apply

D. _____
(Complete title of the licensee's governing body)

E. _____
(Name and title of presiding officer of governing body)

_____
(Mailing address of presiding officer)

_____
(City) (State) (Zip Code) (Telephone #)

F. (1) If a publicly held entity or corporation, does any person or other legal entity own 5 percent or more of the ownership interest or owners' equity of the licensee? ☐ Yes; ☐ No. If yes, then attach a list identifying the name, address, percent and type of ownership claim.

(2) If not a publicly held entity, attach a list identifying the name, address, percent and type of ownership claim of all others.

G. Does any person or other legal entity claim liabilities of the licensee or of the facility or service for which this license is requested? ☐ Yes; ☐ No. If yes, then attach a list identifying the name, address, percent, and type of claim.

H. If the licensee is a corporation or partnership, **you must attach a list identifying all officers** with your initial application and **annually thereafter with each license renewal application**.

10. Real property ownership. Is the land and/or building on/in which the facility or service is conducted owned by the licensee? ☐ Yes; ☐ No. If no, attach a list providing information similar to that required in Line 9, above.

11. Management. Has the licensee engaged an entity other than an employee of the licensee to manage or operate the facility? ☐ Yes; ☐ No. If yes, attach a list providing information similar to that required in Line 9, above.

12. Is there any agreement, contract, option, understanding, intent or other arrangement that will effect a change in any of the information requested and/or provided in Lines 9, 10, or 11 above? ☐ Yes; ☐ No. If yes, attach a complete description of this, including the type of information required in Line 9, above.

13. VERIFICATION

State of_____

County of_____

I, _____and_____
being duly sworn on my oath, depose and say that I have read the foregoing application (and attachments) and know the contents thereof; that the statements contained are correct and true to the best of my knowledge and belief. Furthermore, I understand that I must comply with standards set forth in South Carolina Regulation 61-13, 61-16, 61-17, 61-78, 61-93, or 61-103 (as applicable to the license applied for herein) and that non compliance with these standards may result in the Department pursuing enforcement actions as provided in the applicable regulation
61-13, 61-16, 61-17, 61-78, 61-93, or 61-103.

_____ _____
(Signature)* (Title)

_____ _____
(Signature)* (Title)

An application must be signed by the owner if an individual; or in the case of a limited liability corporation, the head of the limited liability company; or two of the owners if a partnership; or, in the case of a corporation, by two of its officers; or, in the case of a governmental unit, by the head of the governmental department having jurisdiction over the facility.

Subscribed and sworn to before me this ____day of_____, _____.
(Month) (Year)

NOTARY PUBLIC_____

My commission expires _____ NOTARY SEAL

14. _____ _____ _____
(Name and title of person preparing this application) (Telephone Number) (Date Prepared)

Instructions for Completing DHEC Form 0207
Application for License to Operate an
Inpatient Care Facility

PURPOSE: In accordance with §44-7-260 and §44-71-10, of the South Carolina Code Ann. (Suppl. 2001) and Regulations 61-13, 61-16, 61-17, 61-78, 61-90, 61-93, and 61-103, licensees and prospective licensees must file an application under oath prior to operating a health care facility, and annually thereafter. Licenses are effective for a 12-month period following the date of issue.

INSTRUCTIONS:

Line 1.A. If you are renewing your license, the name of the facility must appear exactly as it did before on your current license. If you are changing the name of your facility, then enter the new name of the facility on line 1.A. and on line 2.C.(2). If the name of your facility is incorporated, then the name on line 1.A. must appear exactly as it appears in the Articles of Incorporation as issued by the Secretary of States Office.

If this is an initial license, we highly recommend that you limit the name to 65 characters (including spaces) as that is the limit of our database. Names longer than 65 characters will necessitate that we abbreviate the name or cut it off after 65 characters. The abbreviated name will appear on all our information that is made available to the public and may not accurately reflect the actual name of your facility if it is longer than 65 characters.

Regardless of our limitations, the name of the facility on Line 1.A. should be consistent with the name of the facility as it appears on other documents submitted during the initial licensure process. Afterwards, if you desire to change the name of the facility, you can submit another application to reflect the change. This will ensure that the name of the facility reflects what you actually intended the facility to be called.

Line 1.B. Enter the address of where the facility is physically located and include the phone number to the facility.

Line 1.C. Enter the mailing address if it is different from the location address. If it is the same, enter ASame" on this line.

Line 1.D. Enter the e-mail address of the facility.

Line 2.A.B. Check the appropriate response as to your reason for submitting the application.

Line 2.C. If you are making a change that will alter the face of your current license, check this box. (See Notice on page 1 of this application.)

Line 2.C.(1) If this is a change in licensee, **the application should be completed by the individual or entity that will become the new licensee for the facility,** as licenses are not transferable. Regardless of the party that completes the application, the signatures on Line 13 must be that of the new licensee. Our Department will continue to recognize the current licensee as the owner of the license until our office has approved the application for change in licensee. Until we grant approval to issue a new license to the new licensee, the current licensee is responsible for renewing the current license prior to the expiration date and must submit a separate application to renew the current license. Enter the name of the current licensee on the first space provided and the name of the new licensee on the second space provided.

Line 2.C.(2) Enter the current name of the facility on the first line and the new facility name on the second line. We highly recommend that you limit the new name to 65 characters (including spaces) as that is the limit of our database. Names longer than 65 characters will necessitate that we abbreviate the name or cut it off after 65 characters. The abbreviated name will appear on all our information that is made available to the public and may not accurately reflect the actual name of your facility if it is longer than 65 characters.

Line 2.C.(3) Enter the old address of the facility on the first line and the new address on the second line. Indicate if this is a change in mailing address or location address. (**Note: You cannot move the licensed activity to another location without prior approval from our office. Such a change would necessitate an application as a new or initial license.**)

Line 2.C.(4) Enter the current number of beds you are licensed for in the first space provided and the new number of beds you are applying for in the second space whether it is an increase or decrease of the current number of beds and, reflect this increase or decrease in the appropriate category on Line 4. If you are holder of a CON, attach a copy of the letter approving or exempting the increase/decrease from CON review.

Line 3. Check the appropriate boxes and enter the name and title of the individual designated, as the Administrator of the facility with who contact between our Department and the facility will be made. For Nursing Homes, this must be the individual licensed by the South Carolina Board of Long Term Care Administrators, Department of Labor, Licensing and Regulation. As such, you must enter the Administrators License Number and the expiration date.

Line 4. Only one category for Line 4. (A, B, C, D, E, F, or G) can be checked. If the licensee is the holder of multiple licenses with our Department, you must submit a separate application for each type of license that is held or being applied for.

Line 4.A. Check this block if you are being licensed as an Intermediate Care Facility for the Mentally Retarded as defined in DHEC Regulation 61-13. Check Block A.(1) if you will be licensed for 16 beds or more and enter the total number of beds in the space provided. Check Block A.(2) if you will be licensed for 15 beds or less and enter the total number of beds in the space provided.

Line 4.B. Check this block if you are being licensed as a Hospital or Institutional General Infirmary as defined in DHEC Regulation 61-16. Check only one category for B. (1), (2), (3) or (4). You can only check block B.(4) if you have a Certificate of Need to operate as a specialty hospital. A specialty hospital is defined in Section 101.D.2. of Regulation 61-16 as a facility which provides a specialized service for one type of care such as tuberculosis, maternity, orthopedics, pediatrics, or E.E.N.T., etc.

Enter in the space provided, the number of beds to be licensed for each of the categories listed. The number of beds by each classification added together, must equal the total number of beds in the space provided. Beds can only be licensed as general, psychiatric, rehabilitation, or substance abuse. This is normally indicated in the Certificate of Need letter that you were issued by our Department.

Indicate whether or not you operate a swing bed unit and enter the total number of swing beds in the space provide. (The number of swing beds is not related to the total number of licensed beds discussed in the paragraph above.)

Indicate by checking the appropriate box if your hospital provides perinatal (obstetrics and newborn) services. If yes, then check the box for appropriate level you are authorized to provide. Then, enter the number of neonates you are capable of caring for in the spaces provided.

Indicate whether or not you are accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and the date of the last JCAHO inspection.

Line 4.C. Check this block if you are being licensed as a Nursing Home as defined in DHEC Regulation 61-17. Then check either or both blocks (1) if you have nursing home beds and/or (2) if you have institutional nursing home beds. Enter the number of beds in the appropriate spaces provided.

Line 4.D. Check this block if you are being licensed as a Residential Treatment Facility for Children and Adolescents as defined in DHEC Regulation 61-103. Enter the number of beds you are being licensed for in the space provided.

Line 4.E. Check this block if you are being licensed as a Chiropractic Facility as defined in DHEC Regulation 61-90. Enter the number of beds you are being licensed for in the space provided.

Line 4.F. Check this block if you are being licensed as a Facility that Treats Individuals for Psychoactive Substance Abuse or Dependence as defined in DHEC Regulation 61-93. **(Do not use this application if you are applying for a license to operate an outpatient facility. You will need to complete an outpatient license application).** Enter the number of beds on the appropriate line for each type of treatment or program the facility provides. Enter the total number of beds to be licensed. **(Note: You cannot have Medical Detoxification Beds without a Certificate of Need issued to the licensee from the Department.)**

Line 4.G. Check this block if you are being licensed as a Hospice Facility as defined in DHEC Regulation 61-78. Enter the total number of beds on the appropriate line. **(Do not use this application if you are applying for a license to operate an outpatient facility. You will need to complete an outpatient license application).**

Line 5. Self explanatory. Check the appropriate block and complete as indicated.

Line 6. Self explanatory. Complete as indicated. Attach additional sheet(s) if necessary.

Line 7. Self explanatory. Complete as indicated. Attach additional sheet(s) if necessary.

Line 8. Self explanatory. Complete as indicated. Attach additional sheet(s) if necessary.

Line 9. If you have procured the services of a management company to run the facility on behalf of the licensee, the management company **is not** the licensee. Information pertaining to the management company is requested in Line 11. Only information pertaining to the licensee is requested in Line 9.

Line 9.A. If the licensee is an individual (sole proprietorship), enter his/her legal name. All others must enter the name as legally registered to do business in this State, as listed in the Articles of Incorporation, or as indicated on the Certificate of Need that was issued.

Line 9.B. The mailing address must be that of the licensee, where the individual or entity receives mail.

Line 9.C. Only one block per category (1), (2), and (3) shall be checked. If the license is for a renewal, and you check any block different from the previous application, you must attach a full explanation and any other pertinent documentation to support the change. (**Note: You cannot arbitrarily change from a sole proprietorship to any other category without an official notarized agreement if a partnership or; articles of incorporation if a limited partnership, corporation or limited liability company.**)

Line 9.D. Enter on this line the complete title of the licensee's governing body. If sole proprietorship, enter the individual's name on this line. Generally, the governing body is a board of directors elected or appointed and is usually within the organization or entity that is the licensee.

Line 9.E. Enter the name, title, mailing address, and phone number of the individual that is the President or Chief Executive Officer (CEO) of the governing body.

Line 9.F. Self explanatory. A publicly held entity is one which is offering or has ever offered it's stock for sale on a public exchange.

Line 9.G. Self explanatory.

Line 9.H. If the licensee is a corporation or partnership, **you must attach a list identifying all officers** with your initial application and each subsequent license renewal application.

Line 10. Self explanatory. The licensee must be the sole owner of the property unless the licensee has entered into a legal lease or rental agreement with the real property owner.

Line 11. If the licensee has procured the services of a management company to operate the facility, attach a list providing information similar to that required in Line 9. The management company under no circumstances is the licensee.

Line 12. Self explanatory.

Line 13. Self explanatory. The verification signatures must be those of the individuals who are officers of the Licensee's governing body. Individuals belonging to a management company or other persons who are not officers of the governing body cannot sign on behalf of the licensee. In the case of a sole proprietorship, the signature must be that of the person identified on Line 9.A. If the license application is being notarized outside of the State of South Carolina, the notary seal of that State in which it is notarized must be affixed to the application. Otherwise, if the application is being notarized by a Notary registered with the State of South Carolina, the notary seal is not required to be affixed to the application.

Line 14. Self explanatory.

OFFICE MECHANICS AND FILING: The original shall be placed in the Master File of the activity in the Health Licensing Section and kept there in accordance with the most restrictive retention schedule assigned to this document or other documents contained in the file. The most restrictive retention schedule in our Master Files is SBH-F&S-17, which requires documents to be kept for 6 years within Health Licensing. Records are then shipped to the Consolidated Storage Center for retention of not less than twenty-four years before destroying.